Money Follows the Person

Transition Guide

for returning to the community

KANSAS

MONEY FOLLOWS THE PERSON

For more information, contact:

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Notes

WOULD YOU LIKE TO RETURN TO YOUR HOME OR COMMUNITY?

THE "MONEY FOLLOWS THE PERSON" PROGRAM COULD BE YOUR ANSWER!

MONEY FOLLOWS THE PERSON

IF YOU HAVE:

- MEDICAID ELIGIBILITY AND AT LEAST 6 MONTHS RESIDENCY IN YOUR FACILITY…AND
- HAVE A STRONG DESIRE TO GO HOME

READ ON

This booklet should help you understand what is available through the *Money Follows the Person* program and how to consider the type of support and services you will need to successfully move back into your home or community. In addition, there is information helpful to you to make this move.

With *Money Follows the Person,* you are not alone. You will get help to plan what support you will need to make the move to live within your community. There will be a number of people in your resource team, but likely there will be one who coordinates and oversees your move. This will be your Case Manager--the major person to help you through this "long-term care system."

INTERESTED IN MOVING?

The first step is to express your interest in the *Money Follows the Person* program. Even if you decide not to participate, there will be no penalty or loss of any benefits.

HOW DOES THE PROCESS BEGIN?

A Community Bridge Building Team Will Meet with You.

This meeting will consist of an interdisciplinary team of people meeting with you to discuss the MFP program and explore community living options. The team will explore your desire to return to the community and help you to begin identifying individualized community support networks. If you are still interested in returning to the community after meeting with the team, a Transition Coordinator will work with you to begin discussing your transition process.

HOW ARE SERVICES FUNDED?

Money Follows the Person services are funded through a variety of resources. Some may come from existing community programs such as Meals on Wheels or an in-home caregiver.

Your other services and supports not currently available through existing programs will be funded by the *Money Follows the Person* project. These particular funds are only available for a limited time period--365 days from the day you leave this facility. But, at the end of the 365 days you'll automatically transfer to another program called Home and Community Based Services (HCBS) which will continue to meet your needs. Money Follows the Person services are funded by Medicaid.

Transportation

Transportation services vary depending on where you live. For example, one location may have accessible public transportation with daily runs until midnight, while another may have accessible transportation with limited service routes ending at 6 p.m., and a third may not have public transportation at all.

Your Case Manager will help explore transportation options for the community in which you choose to live. You may be able to receive medical transportation assistance from Medicaid.

Social and Recreational Activities

The types of social and recreational activities available depend on where you live as well as your own preferences for what you enjoy, such as church, sporting events, school programs, movies etc. This area is important for you to explore early on as you consider communities you want to live in. Some communities may not offer opportunities you consider important.

Social interaction and recreation is, at times, as important as getting your physical needs met.

If you have any other questions, please ask.

Housing

Your home is the foundation of living independently. It is important to begin exploring housing needs and availability early in your transition planning.

Unfortunately, there may be a lack of affordable, accessible housing in some areas of Kansas. Use every resource available to you in finding housing. Tell neighbors, friends, family, etc. what you are looking for.

A realistic budget is important. How much can you afford for living expenses? Generally one-third of your income for housing expenses is a good guideline. This also will need to include utilities if they are not included in the rent. Your Transition Coordinator will work with you to explore the possibility of housing/rental assistance.

Once you have an idea of what your housing needs and resources are, you also need to consider other factors, such as furniture, moving expenses and security deposits. Please remember, *Money Follows the Person* can help with some of the moving expenses, if needed.

If there is a need for home modifications (door widening or ramps), *Money Follows the Person* can help you with these expenses as well.

There may be one-time-only expenditures or services covered by *Money Follows the Person* that you'll need for your initial move back home. These may include one or more of the following:

- Intensive relocation support
- Moving support and expenses
- Home health
- Rental and utility deposits
- Independent living skills and community access consultation and training
- Assistance technology and durable medical equipment
- Home modifications

You and your Case Manager will develop a plan of care made up of community services and supports as well as any informal help you have from your resource team.

And, once everything needed is in place for your move, this guidance, encouragement and support will continue to be provided. Your case manager will **contact you** periodically to make sure you are getting the help you need to remain independent and safe in your community. You can call your Case Manager anytime you have a question, concern or problem.

YOU'RE NOT ALONE; YOU WILL HAVE A RESOURCE TEAM

Once you have decided that you are interested in returning back to the community, a Transition Coordinator will be there to help you. You don't have to make this move all by yourself! The Transition Coordinator will help you develop a resource team made up of anyone who contributes to your physical, mental or emotional well-being.

Building this resource team can sound challenging at first. But all it really means is drawing together a group of people who can help you get the resources, support and services you will need.

For example, this could be family and friends…staff from the facility where you currently live…health care practitioners…or even a beloved pet.

It is important that a resource team is built to help you throughout this move. This team will add new people for building other needed resources for your move back into the community. Your Transition Coordinator will help you construct this team of supporters.

The first people who may become part of your Resource Team are family, friends, facility staff members, facility visitors and others with whom you may have had contact. Some others may become another source of support. You may ask them also to become a support team member. These are often known as a "natural support" and are usually there for the long haul. They could be friends, neighbors, relatives or volunteers. Their roles may be only informational, advisory or supportive, but they also may provide help with errands or tasks.

Peer support from people with similar experiences can be especially helpful. These people have been where you are or are facing similar challenges.

If you have a court-appointed guardian or conservator, he or she will have a level of authority in making decisions for you. Your Transition Coordinator will work with both you and your guardian to decide the best community living options.

Assistive Devices

The use of assistive devices or home modifications are important tools for independence. Your Case Manager will help you determine the type of assistive technologies or home modifications you will need.

These will have to be acquired or completed before you leave your present facility so you will have time to learn to use the devices effectively or to have the needed home modifications completed before you move into your new community. Examples of home modifications may include ramps, wider doorways, shower modifications, etc.

Money Follows the Person can assist you with purchasing durable medical equipment (grab bars, stool riser, shower chairs, etc…) and some type of needed home modifications as well as vehicle adaptations.

Health Services and Supplies

Health care in the community is quite different from that in a facility. It is important to fully understand your medical condition and needs so that adequate medical support services and medical supplies for you are in place before you leave the facility.

It is important that your attendants are trained to carry out specific medical treatments or therapies that you may need.

THE FUNDING -- EXISTING MEDICAID PROGRAMS AND SERVICES

You may be eligible for a variety of services or programs to help people with basic needs such as food, medical needs, help with personal care, transportation and other types of assistance for living in the community. Medicaid programs and services are different in a community from those in a nursing or other facility. They also will vary depending on where you might live.

Here are the types of services and programs that may be available.

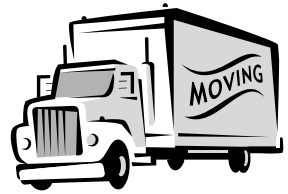
Support for Living in the Community

Living independently doesn't mean you do everything without other people's help. We all rely on others and have others who rely on us. But you have control over what services you receive and how they are delivered. YOU are the person in charge!

If you need help with personal care, such as bathing, eating, going to the bathroom, etc., or managing your home, or cooking, a personal attendant can help you with those needs. You can either have an agency hire an attendant or you can self direct. If you choose to self direct your services, you will be hiring and supervising those that provide you with services.

Your Case Manager will help assess your eligibility for different services and will know what is available locally. You will get help to set up these needed services.

HOW DO YOU START THE TRANSITION (OR MOVING) PROCESS?



Your Transition Coordinator will work with you to develop a successful transition plan. This planning is different from the assessment you completed when you first entered your present facility. This transition plan looks at your support and care needs and how they can be met in your new community versus your present facility. Other items to explore more deeply in this assessment are:

- What strengths, resources and qualities you successfully have that will help you return to your home or community.
- What concerns or other items you believe may be barriers to this successful move, and what can be done to remove these.
- What strengths and resources are available from your family, friends and your new community which will help you succeed.
- What goals you have and want to meet within your new community.
- What other issues you may need more information regarding.

Once this transition assessment is complete, you and your Transition Coordinator will explore your options for needed services. This discussion will include services, support, resources, housing, people and other items needed to return to your community successfully.

As your needs change your transition plan can change to accommodate you. It is important that you tell your Transition Coordinator of changes or concerns that you have.

THE TRANSITION ASSESSMENT

Here are examples of many of the items you need to talk about with your Transition Coordinator. If you don't have the information and need help collecting it, or need to have it defined further, your Transition Coordinator will help.

- Your Transition Coordinator needs to know how much monthly income you have along with any financial issues which might hinder your transition to your community.

- Do you still have a bank account? If not, you will need to get one. You might want to set up automatic deposits of your benefits before you leave your present facility.

- Are there problems that may have an impact on your ability to access some programs, such as housing? These could be with your present credit, such as unpaid utility bills, a past criminal record, drug or alcohol abuse problems, or evictions.

- Do you have access to your important papers? You will need your birth certificate and Social Security card. If you need to get replacements, your Transition Coordinator can help.

- It is important to be totally honest with your Transition Coordinator. The sooner you reveal any problems, the sooner solutions can be identified.

WHAT WILL YOUR CASE MANAGER DO?

If you are eligible and become part of *Money Follows the Person*, your Case Manager will work closely with you in the planning period throughout your move back into your community, and during the program's time period of 365 days from the day you leave your present facility. You and your case manager will develop a Plan of Care to meet your needs.

Your Plan of Care is "person centered" for only you. This person centered plan will focus on your strengths, needs and goals. You are the decision maker in this planning process and a good plan will be built around your individual needs and goals. Make sure this is a well thought out plan for it is your best chance for success.

Your Case Manager will work with you to:

- Create a Plan of Care to identify and locate the services, support and resources you need to move as well as throughout the program’s time period.

- Provide support, assistance and information as needed.

- Contact you periodically to make sure your needs are still being met.

Your Plan of Care is a "working" document. Periodically, your resource team--you, your Case Manager and others--will review and revise it as your needs change.